

WELCOME to STEWART DENTAL *the Smile Shoppe!*

Patient Information

Date of Birth: _____ SSN: _____
Name you prefer to be called: _____ Single Married Divorced Widowed
Legal Name: _____
Lives with, name & relationship: _____ / _____
Address: _____ City, State, Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
E-mail: _____ Best Way to contact: Home Cell Work
 Text Email
Who may we thank for referring you? _____
Emergency contact / Relationship: _____
Emergency Phone: _____

Person Responsible for Account

Name: _____ Relationship: Self or Other _____
Address: _____ Date of Birth: _____ SSN: _____
City, State, Zip: _____ Driver's License #: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Dental Insurance Information

Employer: _____ Employee: _____
Insurance Company: _____ Date of Birth: _____ SSN: _____
Insurance Phone: _____ ID#: _____ Group #: _____

HIPPA Consent

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date